

Mental Retardation Community Medicaid Services

____ New
for CSP Year

____ Revision
for CSP Year

INDIVIDUAL SERVICE PLAN

Estimated Duration: _____

Indicate Service: ☒ Residential Support ☐ Supported Employment ☐ Day Support ☐ Prevocational

Individual: _____ Medicaid Number: _____

Code: _____ Provider Name: _____ Provider Number: _____

Responsible Staff (name or position of implementer of the plan): _____

Start Date: _____ End Date: _____ Quarterly Review Dates: _____

Goals/objectives are based on up-to-date assessment information present in the file.

CSP SELECTED GOAL/ DESIRED OUTCOME: _____ will live in a supervised apartment setting within the next 3 years.

OBJECTIVES (<i>RS Examples in italics. Complete, revise, delete or add any per individual's needs.</i>)	TARGET DATE	ACTIVITIES/ STRATEGIES (<i>RS Examples in italics. Complete, revise, delete or add any per individual's needs.</i>)
1) _____ will select weather appropriate clothing each morning, with only 1 verbal cue, for 14 consecutive days.		Staff will ask _____ what he wants to wear each morning after informing him what the weather is to be like that day.
2) _____ will greet at least two people, with one verbal cue each, every time he goes out into the community for 14 consecutive days..		Staff will encourage _____ to look people in the eyes and extend a verbal greeting (e.g., "hello" or "hi there") whenever he is in the community for shopping, banking or leisure activities.
3) _____ will receive overnight specialized supervision to prevent him from wetting the bed.		_____ will be awoken by staff every three hours during the night to use the toilet. If _____ should have wet the bed when staff check on him, _____ will be assisted in washing up and changing pajamas & bedclothes.
4) _____ will receive needed assistance in the following areas: - morning routine: washing face, brushing teeth, dressing, combing hair, preparing breakfast - evening routine: showering, brushing teeth, dressing, combing hair, preparing for bed - community integration activities - housekeeping activities		Staff will provide needed verbal assistance to ensure ADLs and IADLs are completed. Frequency: daily

Individual: _____ Service: _____ Start Date: _____

<p>OBJECTIVES</p> <p><i>(Examples in italics. Complete, revise, delete or add any per individual's needs.)</i></p>	<p>TARGET DATE</p>	<p>ACTIVITIES/ STRATEGIES</p> <p><i>(Examples in italics. Complete, revise, delete or add any per individual's needs.)</i></p>
<p>5) _____ will receive needed assistance/supervision for the following known health/safety issue(s):</p> <ul style="list-style-type: none"> - medication administration 		<p>Staff will perform the following procedures to assist _____ with his/her health/safety issues:</p> <ul style="list-style-type: none"> - verbally remind him that it's time to take medications, supervise his removal of meds from bubble pack and their consumption. <p>Frequency: 2x/day</p>

Individual: _____ Service: _____ Start Date: _____

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

Individual: _____ Service: _____ Start Date: _____

TOTAL HOURS/ UNITS PER WEEK _____

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

NOTE: Day Support, Prevocational and Group Model Supported Employment Services are limited to 780 units per year. This includes combinations of any of the above, as well as combinations that include Individual Competitive Supported Employment.

COMMENTS:
(Role of other agencies if plan a shared responsibility)

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*